

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029441

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 2724

Primary Registration District No. 3052

Registrar's No. 258

FILED JUL 29 1963

VS 300
Rev. 4/59

1 0808

2 0800

3

4 1

5 0

6

7 0

8 0

9 331X

10

11

12 86-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Pettis

b. CITY (If outside corporate limits, give TOWNSHIP only)
Sedalia

Length of stay in 1b
2 1/2 yrs

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION
Campbell Nursing Home

Inside Limits
Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Pettis

c. CITY OR TOWN Sedalia

Inside Limits
Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location)
RFD # 1

Reside on Farm
Yes ☒ No ☐

3. NAME OF DECEASED
(Type or print)

First Kate

Middle

Last McGehee

4. DATE OF DEATH

Month July Day 26 Year 1963

5. SEX
Female

6. COLOR OR RACE
White

7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH
5-8-1869

9. AGE (last birthday)
94

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
Pettis Co. Mo

12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

William M. Gehee

13b. MOTHER'S MAIDEN NAME

Katherine Drew

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.
None

17. INFORMANT
Leo Coffey - Sedalia R 1

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral aneurysm

INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Generalized arteriosclerosis

DUE TO (c)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Feb 1961 to July 1963 and last saw her alive on 16 April 1963
Death occurred at 3:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

(Licensed Embalmer's Statement on Reverse Side)

Dr. Proctor

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed K.P.M. Leary

Licensed Embalmer No. 2153

P. O. Address Sedalia, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.